

State of California
Department of Industrial Relations
Self Insurance Plans
2265 Watt Avenue, Suite 1
Sacramento, CA 95825
Web site <http://sip.dir.ca.gov>
E-mail: sip@dir.ca.gov

PRIVATE GROUP SELF INSURER’S ANNUAL REPORT

I. GENERAL

1. GROUP CERTIFICATE NUMBER:

- - -

☐ Active ☐ Revoked

2. PERIOD OF REPORT:

☐ Full Year ☐ Interim/Amended Report for the Period of:
 to
Month Day Year to Month Day Year

3. NAME OF GROUP CERTIFICATE HOLDER:

NAME

ADDRESS OF MAIN HEADQUARTERS

CITY

STATE

ZIP + 4

State of Incorporation:

Federal Tax Identification No.:

First 4 Digits of Your North American
Industry Classification System (NAICS):

**4. During the reporting period of this report, has there been any of the following
with respect to the Group Certificate Holder or any member?**

- (a) Reincorporating
(b) Merger
(c) Change in Identity
(d) Any additions to Self Insurance Program

☐
☐
☐
☐

Yes
Yes
Yes
Yes

☐
☐
☐
☐

No
No
No
No

If yes, explain: _____

(Continue on reverse side of this page if necessary.)

5. EMPLOYMENT AND WAGES PAID IN CALENDAR YEAR 2003 (Total of all Members):

(a) NUMBER OF EMPLOYEES _____
(For which a W-2 Tax Form was issued for California employment in Calendar Year 2003)

(b) TOTAL WAGES AND SALARIES PAID \$ _____
(As reported on EDD Form DE-6 Line M for all four quarters)

6. TO WHOM DO YOU WANT CORRESPONDENCE ADDRESSED?

NAME/TITLE: _____

COMPANY NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP+4: _____

PHONE: () _____ FAX: () _____

E-MAIL ADDRESS: _____

**SUBMIT TWO (2) COMPLETE REPORTS OF PAGES 1 THROUGH 5
INCLUDING LIST OF OPEN INDEMNITY CLAIMS**

REPORT IS DUE MARCH 1, 2004

Note: This form is required to be submitted on 8 1/2 X 14-inch paper.



GROUP CERTIFICATE NUMBER: - - -

4. (Continued) _____

7. List the full legal names of each group member having an affiliate certificate whose liabilities are being reported under this annual group report, the certificate number of each such member, and its federal tax identification number.

Also include the Employment and Wages paid for the applicable calendar year. The number of employees should include all employees for which a W-2 tax form was issued for California employment. The salary information reported should be consistent with the figures reported on the employers EDD Form DE-3 or DE-4 (enter total of figures reported on the DE-3 or DE-4 for all four quarters).

Affiliate Group Certificate No.	Full Legal Name	Member Federal Tax ID No.	No. of Employees in 2003 for this Member	Wages and Salaries Paid in 2003 by this Member
1. _____	_____	_____	_____	\$ _____
2. _____	_____	_____	_____	\$ _____
3. _____	_____	_____	_____	\$ _____
4. _____	_____	_____	_____	\$ _____
5. _____	_____	_____	_____	\$ _____
6. _____	_____	_____	_____	\$ _____
7. _____	_____	_____	_____	\$ _____
8. _____	_____	_____	_____	\$ _____
9. _____	_____	_____	_____	\$ _____
10. _____	_____	_____	_____	\$ _____
11. _____	_____	_____	_____	\$ _____
12. _____	_____	_____	_____	\$ _____
13. _____	_____	_____	_____	\$ _____
14. _____	_____	_____	_____	\$ _____
15. _____	_____	_____	_____	\$ _____
16. _____	_____	_____	_____	\$ _____
17. _____	_____	_____	_____	\$ _____
18. _____	_____	_____	_____	\$ _____
19. _____	_____	_____	_____	\$ _____
20. _____	_____	_____	_____	\$ _____
21. _____	_____	_____	_____	\$ _____
22. _____	_____	_____	_____	\$ _____
23. _____	_____	_____	_____	\$ _____
24. _____	_____	_____	_____	\$ _____
25. _____	_____	_____	_____	\$ _____

NOTE 1: Add additional page(s) to list additional members, if necessary.

NOTE 2: If more than one claims administrator is used, then liabilities must be reported separately for each claims adjusting location using a Page 2, Liabilities by Reporting Location for Group Member, for each group member.

Calendar Year
2003

From

Date:

Month

Day

Year

To

Date:

Month

Day

Year

A. CASES AND BENEFITS (to nearest dollar)

	Number	Incurred Liability		Paid to Date		Future Liability	
		\$ Indemnity	\$ Medical	\$ Indemnity	\$ Medical	\$ Indemnity	\$ Medical
1. Cases open as of 12/31/2003 reported prior to 1999							
2. Open & Closed Cases:							
a. All cases reported in 1999							
1999 Cases open							
b. All cases reported in 2000							
2000 Cases open							
c. All cases reported in 2001							
2001 Cases open							
d. All cases reported in 2002							
2002 Cases open							
e. All cases reported in 2003							
2003 Cases open							
						\$ Indemnity	\$ Medical
SUBTOTAL							
3. ESTIMATED FUTURE LIABILITY (Indemnity plus Medical) TOTAL						\$ Indemnity	\$ Medical
4. Total Benefits paid during 2003 (including all case expenditures):							
5. Number of MEDICAL-ONLY cases reported in 2003:							
6. Number of INDEMNITY cases reported in 2003:							
7. TOTAL of 5 and 6 (also entered in 2e above):							
8. TOTAL number of open indemnity cases (all years):							
9. Number of Fatality cases reported in 2003:							
10. (a) Number of 2003 claims for which the employer or administrator was notified of representation by an attorney or legal representative in 2003:							
10. (b) Number of non-2003 claims for which the employer or administrator was notified of representation by an attorney or legal representative in 2003:							
11. Attach a List of ALL Open Indemnity Claims (by reporting location and by year) reported and with claims (in alphabetical order) immediately following page 5 of this report. (You may use the form attached or a computer-prepared printout organized in the same format.)							
12. Attach the Specific Excess Insurance Policy page(s) 5.							

Calendar Year

2003

A. NAME OF ADMINISTRATOR(S)/ADMINISTRATING AGENCY(IES) SUBMITTING THIS REPORT.

1. Name (Person) _____

Administrative Agency's

Agency Name _____

Certificate No.:

Address _____

or ☐ Self Administered

City _____ State _____ Zip+4 _____

B. HAS THERE BEEN A CHANGE IN ADMINISTRATOR/ADMINISTRATIVE AGENCY DURING THE PERIOD OF THIS REPORT PERIOD? ☐ YES ☐ NO

IF YES: DATE OF CHANGE:

Month Day Year

TYPE OF CHANGE: ☐ Change in Administrative Agency

☐ Change to or from Self Administration

NAME OF NEW ADMINISTRATOR(S)/ADMINISTRATIVE AGENCY(IES):

Name _____

Agency Name _____

Address _____

City _____ State _____ Zip+4 _____

CERTIFICATION

I declare under penalty of perjury that I have prepared or caused this report to be prepared and I have examined this liabilities report of this self insurer’s workers’ compensation liabilities. To the best of my knowledge and belief this report is true, correct and complete with respect to the workers’ compensation liabilities incurred and paid. I further declare under the penalty of perjury that the estimates of future liability of workers’ compensation claims made in this report reflect the administrator’s best judgment as to the future liability of claims, using prevailing industry standards, and the signatory intends Self Insurance Plans to rely upon the representation.

Original Signature of Administrator (Qualified Person) _____

Date _____

Typed Name of Administrator _____

Name of Administrative Agency or Employer _____

Title _____

Street Address _____

City

State

Zip+4

Phone No. of Administrator () _____

Fax No. () _____

area code area code

E-mail Address of Administrator _____



III. ADMINISTRATOR INFORMATION

- A. Number of Liabilities by Reporting Location for Group Member pages submitted with this Annual Report _____
- B. On Reverse Side of this page 3, identify the names of the Claims Administrators submitting each reporting location report and the Estimated Future Liability (Line 3) from each report.
- C. Total of Estimated Future Liability for all Group Members (itemized on reverse side): \$ _____

IV. RECORDS STORAGE

1. Are any group claim records stored at any location other than with the current administrator?
- ☐ Yes ☐ No If yes, Where? _____
- | | |
|-----------------------------------|-----------------------------------|
| A. Agency Name _____ | C. Agency Name _____ |
| Address _____ | Address _____ |
| City _____ State ____ Zip+4 _____ | City _____ State ____ Zip+4 _____ |
| Phone (____) _____ | Phone (____) _____ |
| B. Agency Name _____ | D. Agency Name _____ |
| Address _____ | Address _____ |
| City _____ State ____ Zip+4 _____ | City _____ State ____ Zip+4 _____ |
| Phone (____) _____ | Phone (____) _____ |

V. INSURANCE COVERAGE

1. Are any of your workers' compensation liabilities in California during the reporting period covered by a standard workers' compensation insurance policy?
- ☐ Yes ☐ No If Yes:
- | | |
|-------------------------------------|--------------------------|
| 1. Name of Insurance Company: _____ | |
| Policy Number: _____ | Policy Issue Date: _____ |
| 2. Name of Insurance Company: _____ | |
| Policy Number: _____ | Policy Issue Date: _____ |
2. Are any of your workers' compensation liabilities in California during the reporting period covered by a specific excess workers' compensation insurance policy?
- ☐ Yes ☐ No If Yes:
- | | |
|---------------------------|--------------------------|
| 1. Name of Carrier: _____ | |
| Policy Number: _____ | Policy Issue Date: _____ |
| Retention Limit: _____ | |
| 2. Name of Carrier: _____ | |
| Policy Number: _____ | Policy Issue Date: _____ |
| Retention Limit: _____ | |
3. Do you carry an aggregate (stop loss) workers' compensation insurance policy?
- ☐ Yes ☐ No If Yes:
- | | |
|---------------------------|--|
| 1. Name of Carrier: _____ | |
| Policy Number: _____ | |
| Policy Issue Date: _____ | |
| Retention Limit: _____ | |
| 2. Name of Carrier: _____ | |
| Policy Number: _____ | |
| Policy Issue Date: _____ | |
| Retention Limit: _____ | |



Member Name	EFL Total [Item 3-Page 2]	Member Name	EFL Total [Item 3-Page 2]
1. _____	\$ _____	51. _____	\$ _____
2. _____	\$ _____	52. _____	\$ _____
3. _____	\$ _____	53. _____	\$ _____
4. _____	\$ _____	54. _____	\$ _____
5. _____	\$ _____	55. _____	\$ _____
6. _____	\$ _____	56. _____	\$ _____
7. _____	\$ _____	57. _____	\$ _____
8. _____	\$ _____	58. _____	\$ _____
9. _____	\$ _____	59. _____	\$ _____
10. _____	\$ _____	60. _____	\$ _____
11. _____	\$ _____	61. _____	\$ _____
12. _____	\$ _____	62. _____	\$ _____
13. _____	\$ _____	63. _____	\$ _____
14. _____	\$ _____	64. _____	\$ _____
15. _____	\$ _____	65. _____	\$ _____
16. _____	\$ _____	66. _____	\$ _____
17. _____	\$ _____	67. _____	\$ _____
18. _____	\$ _____	68. _____	\$ _____
19. _____	\$ _____	69. _____	\$ _____
20. _____	\$ _____	70. _____	\$ _____
21. _____	\$ _____	71. _____	\$ _____
22. _____	\$ _____	72. _____	\$ _____
23. _____	\$ _____	73. _____	\$ _____
24. _____	\$ _____	74. _____	\$ _____
25. _____	\$ _____	75. _____	\$ _____
26. _____	\$ _____	76. _____	\$ _____
27. _____	\$ _____	77. _____	\$ _____
28. _____	\$ _____	78. _____	\$ _____
29. _____	\$ _____	79. _____	\$ _____
30. _____	\$ _____	80. _____	\$ _____
31. _____	\$ _____	81. _____	\$ _____
32. _____	\$ _____	82. _____	\$ _____
33. _____	\$ _____	83. _____	\$ _____
34. _____	\$ _____	84. _____	\$ _____
35. _____	\$ _____	85. _____	\$ _____
36. _____	\$ _____	86. _____	\$ _____
37. _____	\$ _____	87. _____	\$ _____
38. _____	\$ _____	88. _____	\$ _____
39. _____	\$ _____	89. _____	\$ _____
40. _____	\$ _____	90. _____	\$ _____
41. _____	\$ _____	91. _____	\$ _____
42. _____	\$ _____	92. _____	\$ _____
43. _____	\$ _____	93. _____	\$ _____
44. _____	\$ _____	94. _____	\$ _____
45. _____	\$ _____	95. _____	\$ _____
46. _____	\$ _____	96. _____	\$ _____
47. _____	\$ _____	97. _____	\$ _____
48. _____	\$ _____	98. _____	\$ _____
49. _____	\$ _____	99. _____	\$ _____
50. _____	\$ _____	100. _____	\$ _____
Subtotal \$ _____		Subtotal \$ _____	

TOTAL EFL This Page \$ _____

NOTE: Add additional page(s) for additional listings, if necessary.



VI. DEPOSIT CALCULATION

A. Estimated Future Liability

(Sum of Line 3s, Estimated Future Liability, from all individual Liability Reports)

(Page 3, Section III. C.)

(1) Multiply by Deposit Factor x 135%

(2) Minimum Deposit Required \$

B. One Year Average Unpaid Claim Liability Calculation:

(1) Estimated Future Liability \$

(From Line A above)

(2) Less Future Liability of cases prior to 1999 - \$

(Sum of Future Liability [Medical and Indemnity]
from Line 1 of each report submitted)

Future Liability		
\$ Indemnity	+	\$ Medical

(3) Five year total unpaid Future Liability = \$

(4) One year average unpaid liability (Line 3 divided by 5) \$

C. Adjusted Deposit Required Subtotal \$

[Add Minimum Deposit Required to one year unpaid claim liability: Line A(2) + Line B(4)]

D. Adjustment for Specific Excess Coverage \$

(Insert credit for Specific Excess Coverage, if any, from Line 3 on Page 5 Reverse Side)

E. Security Deposit Required to be Posted (Line C minus Line D) \$

Note: Statutory Minimum Security Deposit is \$220,000.

F. Total Security Deposit Currently Posted (All Types) \$

Minimum Deposit Increase Indicated (Line E minus Line F) \$

Increase is Due by May 1.

Minimum Deposit Decrease Indicated (Line E minus Line F) \$ ()

NOTE: Labor Code Section 3701(a) requires every private, self-insuring employer to secure incurred liabilities for the payment of compensation by renewing or making a new deposit of security within 60 days of filing of this annual report, but in no event later than May 1 of each year. Civil penalties of up to \$5,000 for every 30 days or portion thereof that there is a failure to post deposit may be assessed by the Director of Industrial Relations pursuant to Labor Code Section 3702.9 for failure to post required deposit when due.

CERTIFICATE OF COMPANY OFFICER

I declare under the penalty of perjury that I have examined this Self Insurer’s Annual Report and to the best of my knowledge and belief it is true, correct and complete. I am also aware of our company’s duty to post and maintain the required security deposit that is due as a result of this report.

Signature of Group Officer

Typed Name of Group Officer

Title

Name of Company

Street Address

CityStateZip+4

Phone No. () area code

Date



SPECIFIC EXCESS INSURANCE POLICY COVERAGE

Group Certificate No: _____ Name of Group Self Insurer: _____

Note: Instructions to Claims Administrator—See Reverse Side of this Page.

Name of Claimant	Claim No.	Date of Injury	First Year Reported To SIP
Description of Injury		Name of Specific Excess Carrier	
Policy Number	Policy Period From: To:	Employer's Retention \$: Upper Policy Limit \$:	
Claim Reported to Carrier?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Claim Acknowledged/Accepted by Carrier?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has carrier denied any part or all liability of this claim?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Total of payment by excess carrier to date of this claim:		\$	

Employer's Retention		Total Paid on Claim (Indemnity & Medical figures from List of Open Indemnity Cases)		Unpaid Employer Retention Enter "0" if "b." is greater than "a."	
1 a.	\$	Minus b.	\$	= c.	\$
Estimated Future Liability on Claim (From Indemnity & Medical figures from List of Open Indemnity Cases)		Unpaid Employer Retention (Item c. above)		Total Unpaid Carrier Liability	
2 d.	\$	Minus e.	\$	= f.	\$

Name of Claimant	Claim No.	Date of Injury	First Year Reported To SIP
Description of Injury		Name of Specific Excess Carrier	
Policy Number	Policy Period From: To:	Employer's Retention \$: Upper Policy Limit \$:	
Claim Reported to Carrier?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Claim Acknowledged/Accepted by Carrier?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has carrier denied any part or all liability of this claim?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Total of payment by excess carrier to date of this claim:		\$	

Employer's Retention		Total Paid on Claim (Indemnity & Medical figures from List of Open Indemnity Cases)		Unpaid Employer Retention Enter "0" if "b." is greater than "a."	
1 a.	\$	Minus b.	\$	= c.	\$
Estimated Future Liability on Claim (From Indemnity & Medical figures from List of Open Indemnity Cases)		Unpaid Employer Retention (Item c. above)		Total Unpaid Carrier Liability	
2 d.	\$	Minus e.	\$	= f.	\$

Name of Claimant	Claim No.	Date of Injury	First Year Reported To SIP
Description of Injury		Name of Specific Excess Carrier	
Policy Number	Policy Period From: To:	Employer's Retention \$: Upper Policy Limit \$:	
Claim Reported to Carrier?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Claim Acknowledged/Accepted by Carrier?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has carrier denied any part or all liability of this claim?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Total of payment by excess carrier to date of this claim:		\$	

Employer's Retention		Total Paid on Claim (Indemnity & Medical figures from List of Open Indemnity Cases)		Unpaid Employer Retention Enter "0" if "b." is greater than "a."	
1 a.	\$	Minus b.	\$	= c.	\$
Estimated Future Liability on Claim (From Indemnity & Medical figures from List of Open Indemnity Cases)		Unpaid Employer Retention (Item c. above)		Total Unpaid Carrier Liability	
2 d.	\$	Minus e.	\$	= f.	\$

SUBTOTAL Total Unpaid Carrier Liability This Page:
\$ _____

Calendar
Year
2003

Instructions to Claims Administrator

Complete all the information requested on each claim that has estimated incurred liability greater than the minimum retention level of the specific excess insurance policy.

Add the subtotaled carrier liability for all pages necessary to list the claims in excess coverage and then complete the back-side of this form on the last page of the specific excess insurance policy coverage pages in order to calculate the adjustment figure of Specific Excess Coverage to enter on Page 4, Line D of the Group Self Insurer’s Annual Report.

Submit the completed page or pages as Item 12 of Section II, Liabilities by Reporting Location for Group Member, for each Group Annual Report.

Note: You may use this form or a computerized form displaying the same information in the same format.

Calculation of Specific Excess Coverage Entry for Annual Report:

- 1. Total of Carrier Liability Listed on All Pages of “Specific Excess Insurance Policy Coverage” pages attached hereto: \$ _____
- 2. Enter Deposit Rate Applicable for This Group Self Insurer: x _____
- 3. Multiply Line 1 by Line 2 and enter
Specific Excess Insurance Adjustment: \$ _____
- 4. Enter Adjustment Figure on Line 3 above on Page 4, Line D.



LIST OF OPEN INDEMNITY CASES

AS OF _____

(Date)

Reporting Location No.: _____

All Cases on this Page are

Group Certificate Number: _____

For the Year _____

NAME OF GROUP CERTIFICATE HOLDER: _____

Name of Insured or Deceased (Last) (First Initial)	Date of Injury	Description of Injury	Paid to Date		Estimated Future Liability	
			\$ Indemnity	\$ Medical	\$ Indemnity	\$ Medical
(List Alphabetically within year)						